social care
institute for excellence

Safeguarding Adult Review Quality Markers – open training session (5)

Logic model / theory of change

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SCIE

27 October 2022

Welcome!

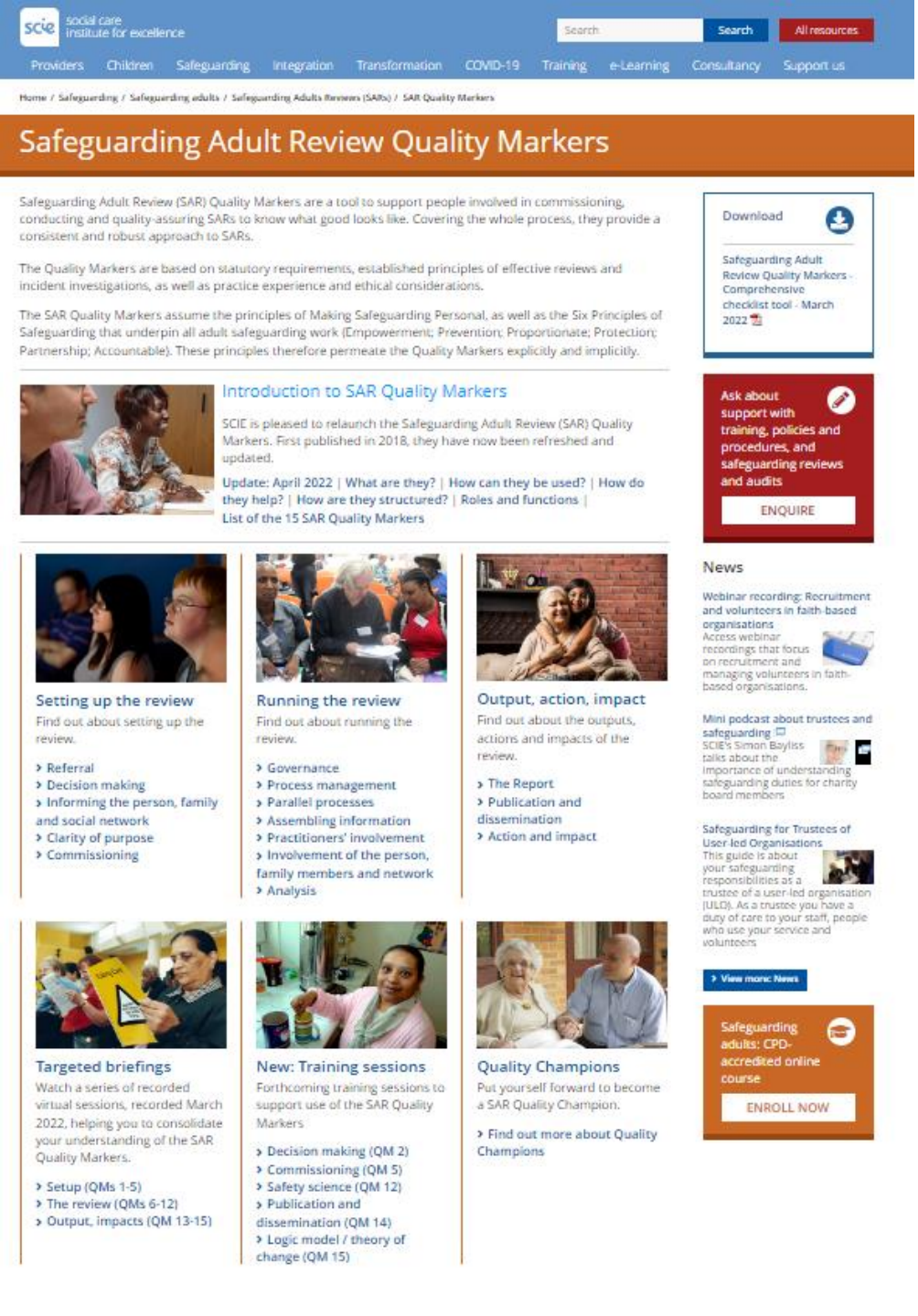
A little bit of context to take us into the outline of the session

SCIE support for high quality learning from SARs

Phase 2. Following the 'refresh' of the SAR Quality Markers; open training sessions to support their use

SAR QMs targeted training sessions - open to all	SAR QM	Agreed date
1. Decision making whether a SAR is needed	SAR Quality Marker 2	Thursday 26th May 9.30-12.00
2. Flexible and bespoke commissioning -	SAR Quality Marker 5	Friday 17th June, 9.30-12.00
3. "Safety science"	SAR Quality Marker 12	Tuesday 28th June, 9.30-12.00
4. Different audiences for publication and dissemination	SAR Quality Marker 14	Wednesday 20th July, 9.30-12.00
5. Logic Model / theory of change	SAR Quality Marker 15	Thursday ~~15th September~~ 27 October 9.30-12.00

Recordings available here: https://www.scie.org.uk/safeguarding/adults/reviews/quality-markers/training2022



[Safeguarding Adults Review Quality Markers - SCIE]

Sessions to date and link to today

QM 2

I. Decision making : being compliant when a mandatory SAR is required; while recognising that the evidence base requires looking at a range of outcomes/practice

II. What counts as a "SAR" –being strategic, proportionate, creative in commissioning SARs

QM 5

QM 4

QM 12

III. "Safety science"; effective approaches to learning use a 'systems approach'; get beyond identifying practice problems evident in a case, to illuminating wider systems findings – what is making it harder or easier to do timely, person –centred safeguarding

CHIP/SCIE webinar on SCIE SAR In Rapid Time model – uses a systems approach; short practical reports focus on 'systems findings'

QM 13, 14 & 15

IV. The implications for thinking about our audiences of publication and dissemination activity – check assumptions that learning from SARs is for operational staff

QM 15

V. Today. Implications for deciding action and evaluating impact

Today: ‘Theory of change’ / logic models
Tools to help deciding action and evaluating impact

1	9.30-10.30	Welcome and agenda for today. Main input: Thinking about taking action and evaluating impact and how a ‘theory of change’ can help
	10.45-11.00	Short break
2	11.00- 11.30	Break-out rooms. Share reflections from your different areas, helpful approaches and ways of working; what would you like more input on
3	11.30- 11.50	Revisit QM 15
	11.50-12.00	Wrap up and close

A flexible session. Stay with us for as many sessions as are useful to you. We’ll share a link to an evaluation form at the end of each session

Learning Outcomes

By the end of the session participants will have:

- Understanding of what is involved in creating a ‘logic model’ or ‘theory of change’ (TOC)
- Appreciation of the benefits of creating a logic model/ToC
- Increased confidence in thinking about the evaluation of actions stemming from SARs from the start

Outline of session 1

1. Brief recap on what kind of learning SARs should be producing when using a ‘systems approach’
2. What QM 15 says about deciding action to address the learning and evaluating impact of actions that follow SARs
3. What we know about current practice relating to improvement action and evaluating impact
4. Tools that can help:
   a) Developing a ‘logic model’
   b) Developing a ‘dark logic model
   c) Developing a description of the intervention /project /change /innovation to be implemented

Quick leg-stretch?

1. Brief recap – what kind of learning do we need

Session 3 – Safety science

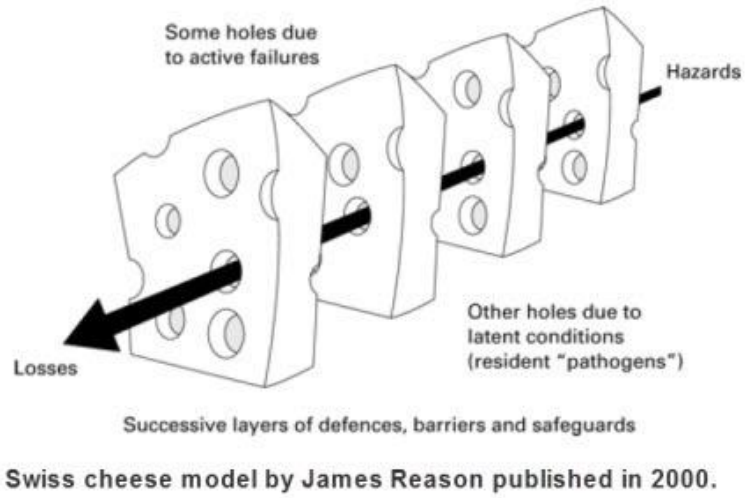
1. Models of why organisational accidents happen.
2. Key systemic ideas that can strengthen analysis in reviews.

The aims of this session are:

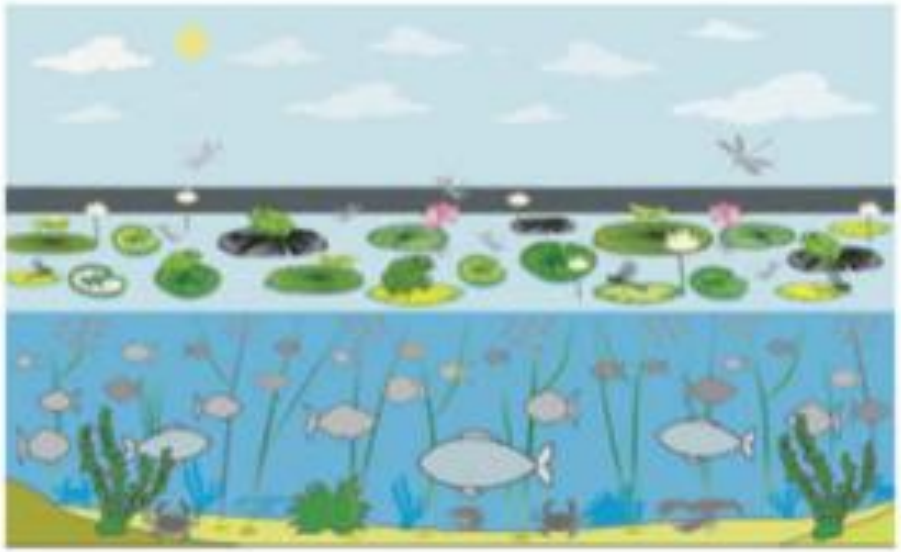
1. To introduce the basic theoretical approaches to understanding the causes of error in high risk fields such as aviation, engineering and health.
2. To give an awareness of some key concepts from these approaches
3. To encourage participants to make connections between some key concepts from systems thinking and their own practice related to SARs
4. To give participants the opportunity to consider what further support would be needed in order to be able to apply systemic thinking in their reviews

Current ‘safety science’ evidence base

From Safety-1 …. to Safety-11



Swiss cheese model by James Reason published in 2000.



From ‘swiss cheese’ ….

…. to ‘lily pond’ model

Quality Marker No.4: Clarity of purpose

4 Quality Marker 4: Clarity of purpose

Quality statement: **The Safeguarding Adult Board (SAB) is clear and transparent, from the outset, that the Safeguarding Adult Review (SAR) is a statutory learning-focused process, designed to have practical value by illuminating barriers and enablers to good practice, untangling systemic risks, and progressing improvement activities. Any factors that may complicate this goal are openly acknowledged.**

Quality Marker No. 12 – Analysis

12 Quality Marker 12: Analysis

Quality statement: **The approach and methodology agreed for the SAR is used with optimum rigour within the size and scope of SAR commissioned. Analysis assumes a systems approach to safety and organisational reliability. It is anchored in relevant research and wider evidence base regarding effective clinical/professional practice and that of safety science. It draws on the full range of relevant information and input assembled, to evaluate and explain professional practice in the case(s) or the responses to earlier learning. Conclusions are of practical value, evidencing the wider learning identified about routine barriers and enablers to good practice, systemic risks and/or what has facilitated or obstructed change to date. There is transparency about any methodological limitations and the implications for the comprehensiveness or level of confidence in the analysis and findings.**

CHIP/SCIE webinar on SAR In Rapid Time model: The model, process and tools assume key methodological principles

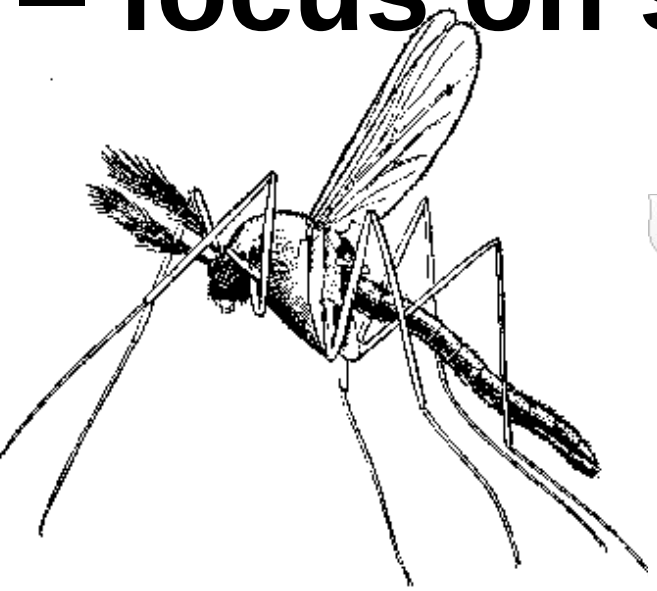
- Assumes and promotes a ‘systems approach’ to practice reviews
  - In line with NHS Patient Safety developments; seen as a discrete specialism see https://www.england.nhs.uk/patient-safety/incident-response-framework/
  - Reflected in the SAR Quality Markers
- Focuses on generating qualitative understandings of social and organisational factors that make it harder or easier for practitioners/clinicians to do personalised, timely and effective adult safeguarding
  - Not ‘root causes’ or linear causality

SAR In Rapid Time model encourages clarity about the kind of learning needed

- The SAR in Rapid Time enables SABs to move from describing practice problems
- To illuminating what lies behind those practice problems
- To understanding the social and organisational drivers for current practice problems

When we say we “keep learning the same things”, is it because we keep identifying the practice problems?

Effective approaches to learning – focus on systems findings



What is making it harder and what is making it easier to do timely and effective safeguarding

SAR in Rapid Time output is a succinct systems findings report

- 5-6 pages
- Only brief paragraph of the case
- Focus on the systems findings

- Feedback to-date positive:
  - Very practical
  - Keeps focus on action required to tackle what's helping and hindering
  - No chance to be distracted by case detail

Nb. There are inevitably compromises to be made, for the benefits of reducing capacity demand and increasing speed of turnaround

Relevance to today

1. We are thinking about taking action to address systems findings; actions to address the barriers/enablers to good practice that the SAR has identified
2. We are thinking about evaluating whether the actions taken have worked to address the causal factors, and had the intended impact on practice thereby

2. Quality Marker 15

Quality Marker No.15: Improvement action and evaluation of impact

15 Quality Marker 15: Improvement action and evaluation of impact

Quality statement: **Improvement actions agreed in response to the SAR set ambitious goals, seeking to align the motivations of different stakeholders, bringing partners together in new ways and foster collaborative working. Actions are integrated, where ever possible, with wider strategic improvement activity, plans and priorities, led locally, regionally or nationally. Evaluation of impact is designed from the start, supported by a logic model or similar, using measures that demonstrate whether the underlying causes of systemic risks identified have been addressed. The SAB maintains a public record of findings, actions and commentary to enable public accountability.**

Quality Marker No.15: Improvement action

15.1.8 Has a logic model or similar technique been used to articulate to the SAB the intended impact and outcomes of proposed actions, for whom, in what timescales and by what mechanisms?

15.1.9 Are SAB expectations clear about plans for longer-term monitoring of improvement actions and follow up to evaluate impact?

15.1.10 Is there agreement about whether follow-up on impact best occurs locally or at a regional or sub-regional level?

15.2.6 Does the plan to evaluate impact match the theory of change for each finding?

3. What do we know about current practice regarding taking action and evaluating impact of SARs?

National analysis of SARs April 2017 – March 2019

3.13. Improvement action

- Within the sample 107 reports (46 per cent) gave some indication, sometimes quite extensive, of early action by agencies. Perhaps unsurprisingly, training (31 reports) and development or revision of policies and procedures (17 reports) feature prominently.
- SABs were asked when contributing to the national analysis to indicate what changes had resulted from the SARs that were included in the sample. 60 SABs (45 per cent) responded to this request for information. Once again, the development and/or revision of policies and procedures (42) and the provision of multiagency training (35) featured most prominently.
- Whilst the feedback from SABs might be indicative of SAR outcomes, it is much less clear how sustained has been the focus on ensuring that changes have been embedded and sustained87 and, therefore, what the impact has been on changing attitudes and beliefs, knowledge and skill acquisition, changes in practice, changes in organisational behaviour and, ultimately, benefits to adults at risk and their families88 .

Improvement priority nineteen
Sector led improvement to engage with SABs on how data can be captured on the impact and outcomes of review activity.

https://www.local.gov.uk/publications/analysis-safeguarding-adult-reviews-april-2017-march-2019

4. Tools to support decisions about actions following SARs and evaluation of impact

- Based on work by Hannah Roscoe when a SCIE Senior Research Analyst
- For the What Works Centre for Children's Social Care
- As part of a WWC project developing support for local authorities to 'self-evaluate' local initiatives and projects
- Today a brief introduction to what many have indicated are new concepts/approaches
- Subsequent work to develop bespoke tools/guidance for SABs and partners – hopefully part of SCIE collaboration with SAR Champions and BMs

Deciding action and evaluating impact requires

Developing clarity about:

What do we want to achieve?

How do we think we will get there?

How would we know if we'd achieved it?

Introduce three main approaches to use:

a). Developing a 'logic model'
b). Developing a 'dark logic model'
c). Developing a description of the intervention /project /change /innovation to be implemented

Provides a set up for evaluation

Quick leg-stretch?

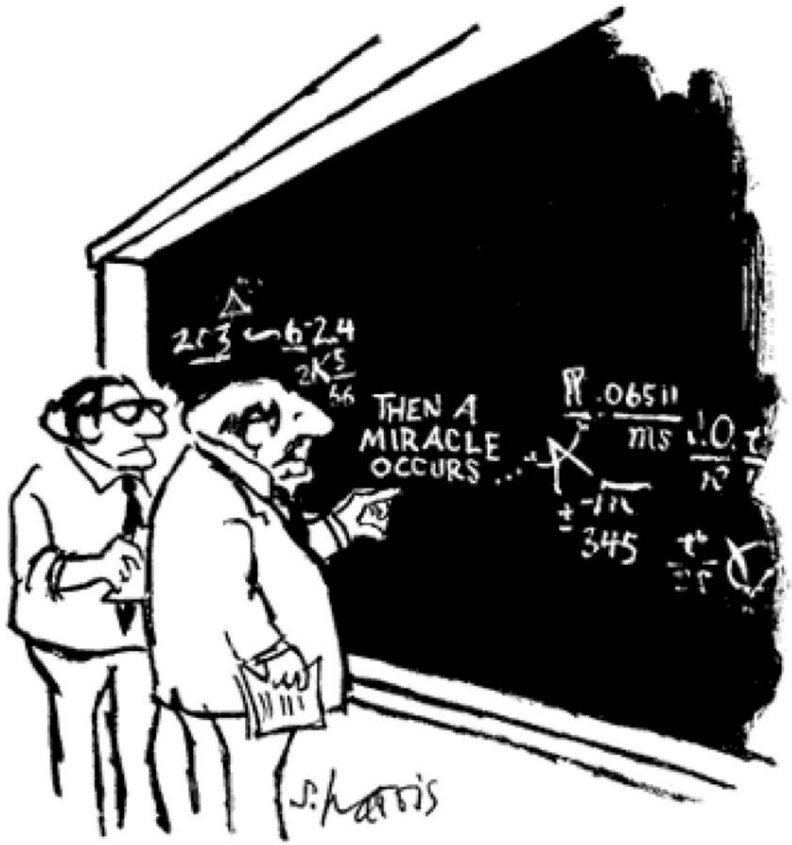
a) designing a logic model

Harries E, Hodgson L, Noble J (2014) Creating your theory of change: NPC's practical guide. London: New Philanthropy Capital.

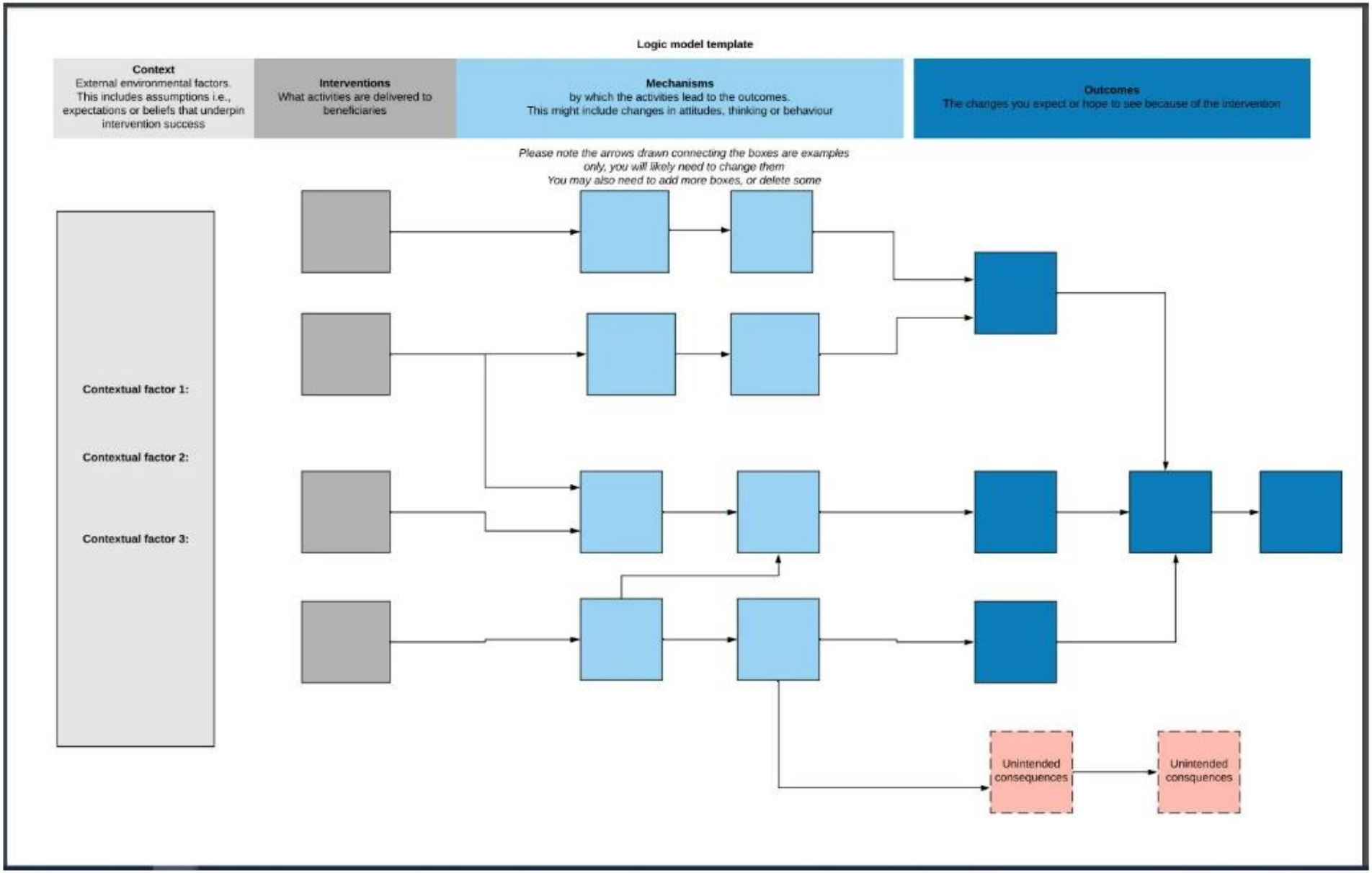
UK Government Introduction to logic models https://www.gov.uk/government/publications/evaluation-in-health-and-well-being-overview/introduction-to-logic-models

What is a logic model?

- Description of how and why a desired change is expected to happen
- Links activities with outcomes, articulating the mechanisms that will lead to change
- Often represented as a diagram

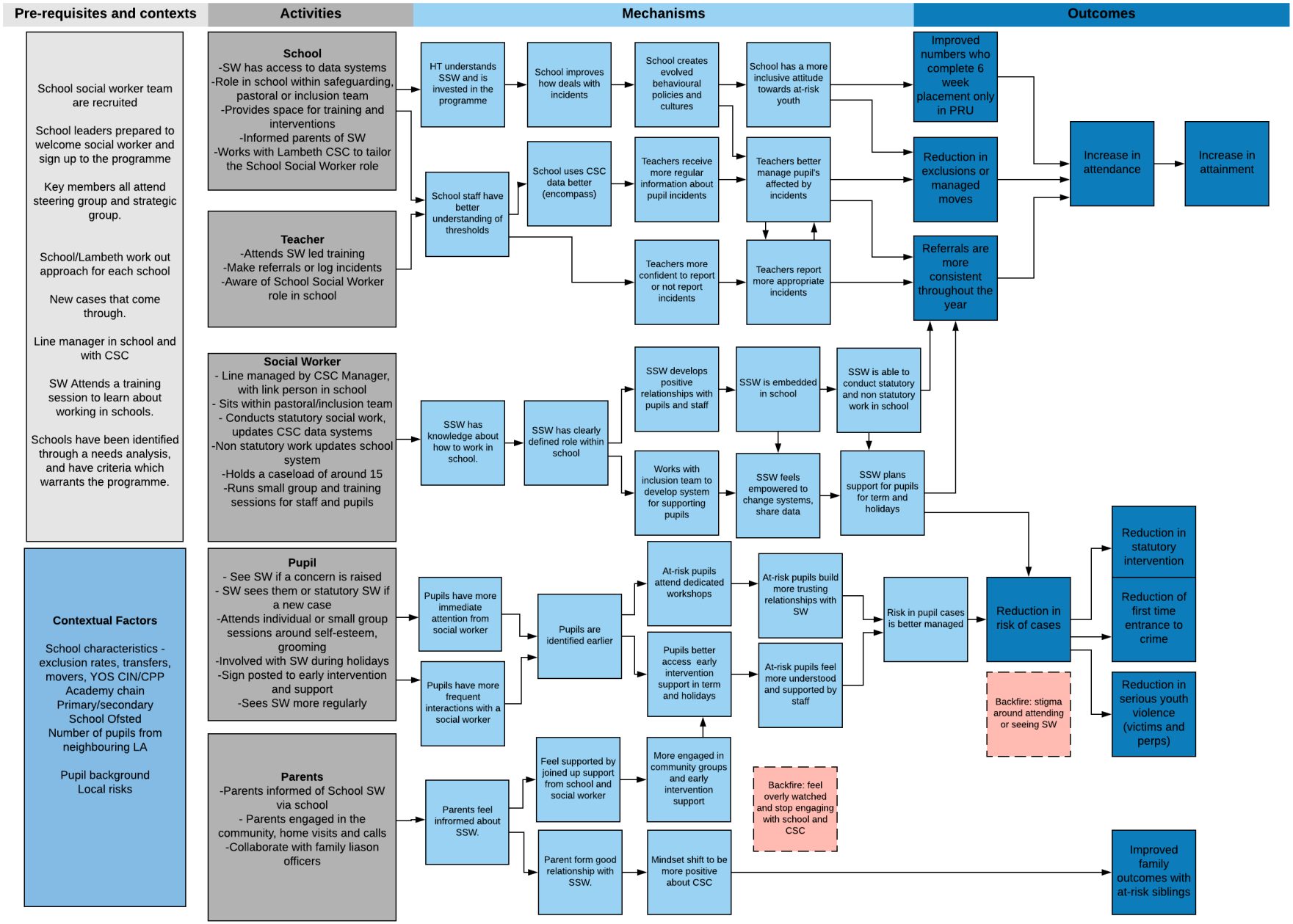


"I think you should be more explicit here in step two."

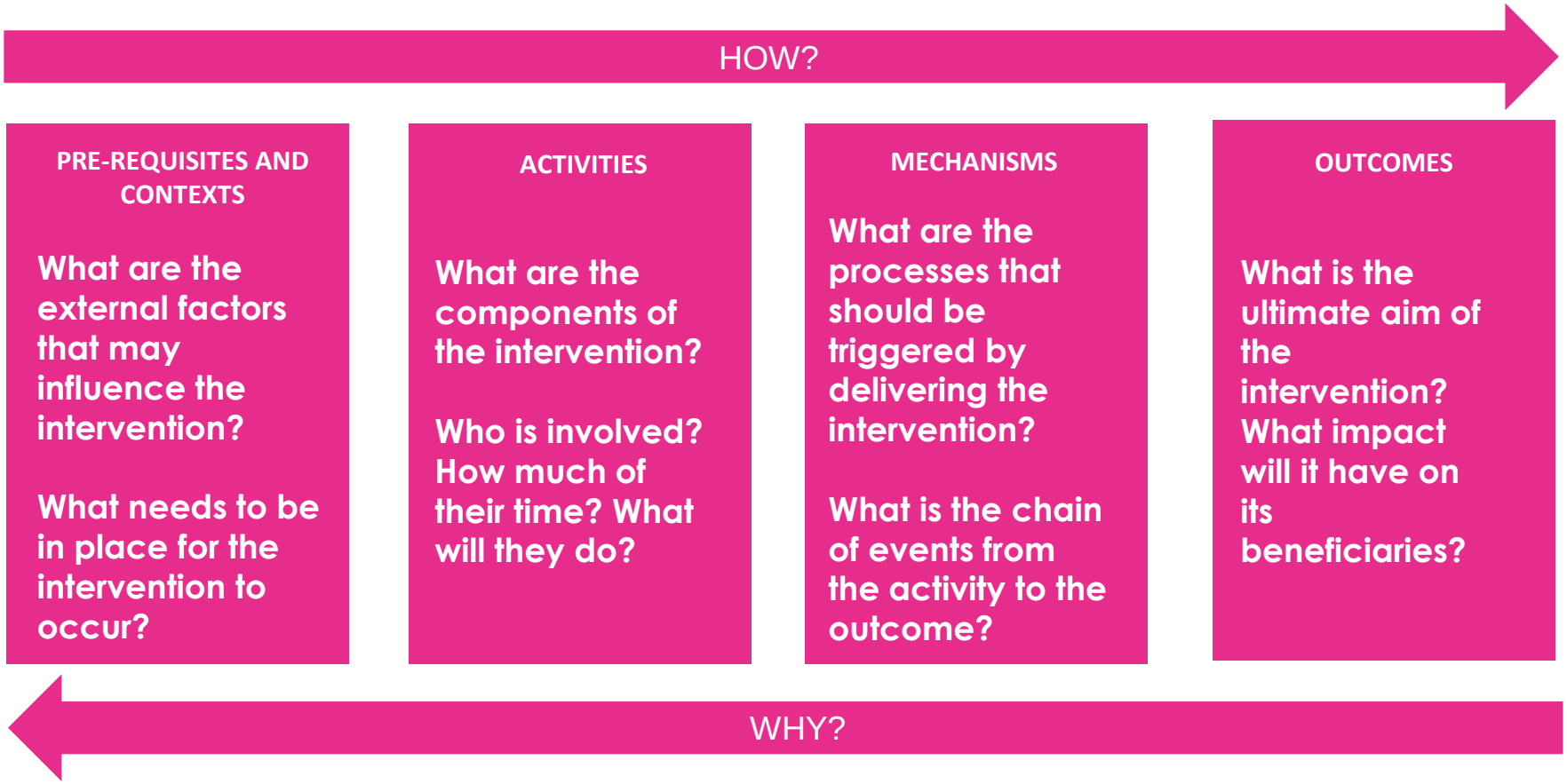


Blank logic model template

Lambeth Logic Model - Social Workers in Schools



Components of a logic model



Project Oracle 'Developing a theory of change for your project'

Harries E, Hodgson L, Noble J (2014) Creating your theory of change: NPC's practical guide. London: New Philanthropy Capital.

Why is it helpful to have a logic model?

- **Clarity and understanding** – achieving a shared understanding of goals and aims; making sure that there is a match between the aims and the activities
- **Improving the intervention** – identifying elements of intervention that 'don't add up' and making changes
- **Communication and partnership** – helping you communicate what you are doing and why
- **Evaluation planning** – helping to identify key outcomes and intermediate outcomes that can be measured via evaluation.

All sound highly relevant to the task of responding to learning from SARs

What makes a good logic model?

Relevant to SAB activities; and potentially provides a format for partner agencies to explain their proposed actions and report back assurances

- **Meaningful** – it influences the design, management and ongoing evaluation of the activity
- **Clear -** Balance detail with giving a clear overview of the intervention
- **Articulates cause and effect** - Give a clear and plausible idea of the expected chain of cause and effect from the intervention to outcomes
- **Plausible and evidence-based -** Where possible, these causal pathways should be based on evidence, for example from similar interventions
- **Testable -** Lead to a set of clear hypotheses that can be tested through evaluation.

How to facilitate the mapping of a logic model?

Facilitator notes:

- start them off with the outcomes they are trying to achieve.

If what they are suggesting is in fact an output (e.g. do some training) ask "why do we want to do that?" to tease out the outcomes they are aiming for.

- get them to describe **activities** with active verbs (*design* curriculum), **outputs and outcomes** in the past tense (young people *recruited*),

- get them to write each activity, output and outcome on a separate post-it and stick them to a wall.

- a whiteboard is ideal as you can draw lines between post-its and easily erase and re-draw them) Otherwise, try and stick up outcomes and outputs first and then connect them with arrows, then discuss and stick up activities and connect them with arrows to the outputs.

- be **challenging** in this session. Especially help them to surface **assumptions** they have made. Good questions include:

- how do you know that will work?
- Have you seen it work here?
- Have you seen it work elsewhere?
- Have you seen something like this work here or elsewhere?
- What circumstances were in place in the context where A caused B?
- Do those circumstances obtain in this context?
- If not, what would we need to do to make sure they did (e.g. change authorising environment, change work process, change IT, work on culture, etc. etc.

Stark contrast to BM being left to develop action plan on their own

Remember Quality Marker No.15:

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b) developing a dark logic model

Bonell, C., Jamal, F., Melendez-Torres, GJ., Cummins, S. (2015) 'Dark logic': theorising the harmful consequences of public health interventions. J Epidemiol Community Health 2015;69:95–98.

Brinkmann et al. (2016) Efficacy of infant simulator programmes to prevent teenage pregnancy: a school-based cluster randomised controlled trial in Western Australia, *The Lancet, 388 (10057),* p.2264-2271.

https://www.theguardian.com/society/2016/aug/26/girls-exposed-electronic-babies-more-likely-pregnant-study

As well as a 'logic model' it is helpful also to develop a 'dark logic' model

- Interventions can sometimes have negative unintended consequences – especially in complex systems

Teenage pregnancy

Girls exposed to 'electronic babies' more likely to become pregnant, study finds

More girls in Australian study who used the dolls - designed to prevent teenage pregnancy - became pregnant than those who did not

Australian Associated Press

Thu 25 Aug 2016 22.15 BST

▲ Teenagers in London with the electronic dolls, which have been used in 89 countries. Girls taking part in an Australian study were found to be more likely to become pregnant if they had been exposed to the dolls

Bonell, C., Jamal, F., Melendez-Torres, GJ., Cummins, S. (2015) 'Dark logic': theorising the harmful consequences of public health interventions. J Epidemiol Community Health 2015;69:95–98.

What is a 'dark logic' model and what is its purpose?

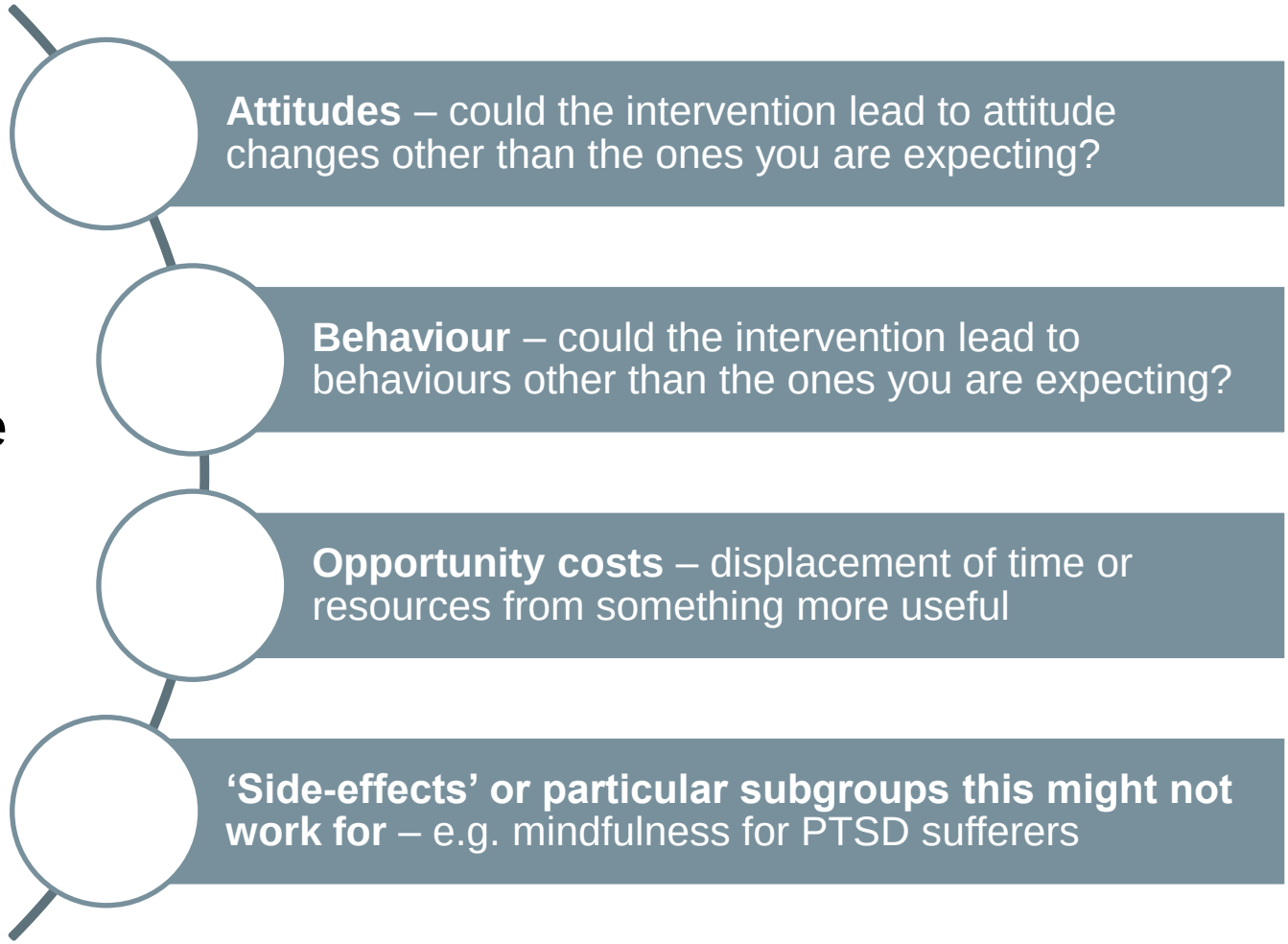
- Interventions can sometimes have negative unintended consequences – especially in complex systems
- The theory of change/logic model sets out how an intervention is intended to work
- The 'dark logic' model sets out possible negative unintended impacts
- We can use this to take steps to prevent/mitigate possible negative impacts
- This approach has been used by Dartington Service Design Lab and Family Nurse Partnership National Unit.

Captured in a table format

Possible adverse effects/ unintended consequences	Likelihood	'Early warning signs' – how would we know?	Mitigating actions
E.g. Social workers do not try out as many creative ways of working with families, as they know they can refer to the panel			

Useful prompts might be …

- We are aiming to think about ways that the mechanism of the programme might not work in the way we imagine…
- Might be helpful to think about…



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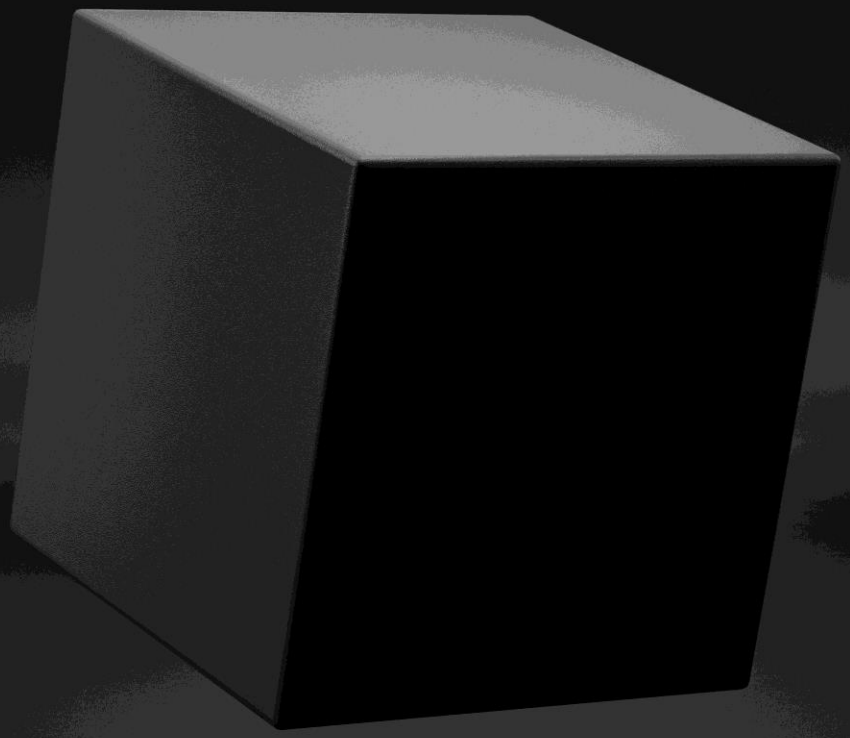
c) describing the intervention

It is not unusual for an evaluation to conclude that something works without explaining clearly nature of the activity sufficient for it to be replicated.

We need to open the black box and describe our activities in a systematic and structured fashion



Unpacking the black box - what is it that we're doing?

The TIDieR Checklist

To promote better and more consistent reporting of interventions in research studies, Hoffman and colleagues developed a template for intervention description and replication (TIDieR). This provides a helpful checklist for ensuring that the key elements of an intervention have been considered and described. This makes it easier for others to replicate it and for researchers to study it.

Hoffman, T. et al (2014) Better reporting of interventions: template for intervention description and replication (TIDieR) checklist and guide, BMJ, 348, DOI 10.1136/bmj.g1687

Describing a project/ intervention/ innovation

Key elements

- Why – what's the rationale?
- What – what will be done (including procedures to be followed and materials required)?
- Who – what expertise, background or training will be required
- How – what is the mode of delivery?
- Where – the type of location and relevant features?
- When and how much – frequency, duration, schedule and number of sessions?
- Tailoring – in what way can the intervention be tailored to the recipients needs?
- Monitoring – how is the intervention's delivery monitored?

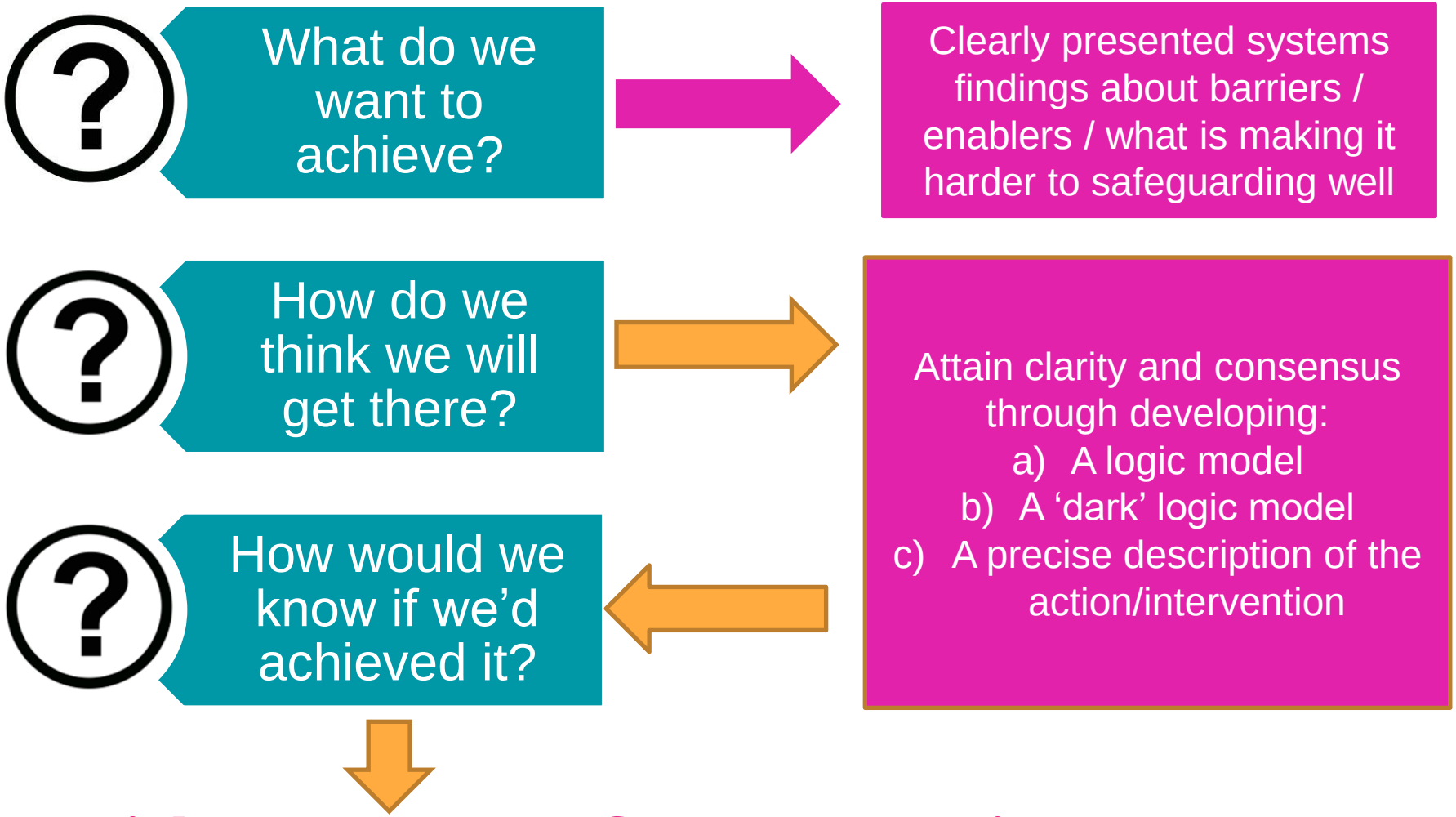
Pertinent if effective responses are to be shared

Recap

Deciding action and evaluating impact

Requires developing clarity about:

And these tools/approaches can help:

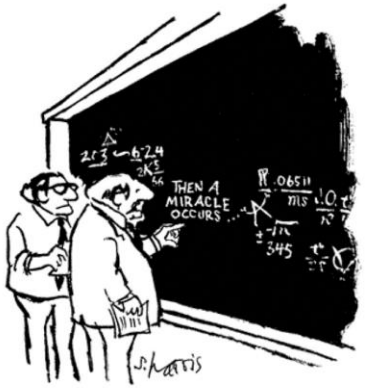


Provides a set up for evaluation

Coffee break

SESSION 2. Break-out rooms

- Sharing reflections on input this morning
  - Any familiarity with the use of ‘logic’ and ‘dark’ logic models
  - Helpful tools to aid specificity and surface assumptions abou cause and effect?
  - Are you specific enough about actions that they could be replicated?
  - What evaluation expertise among your partners?
- Any local practice / developments that are useful to share relate to deciding action and evaluating impact?
- What more would you like clarity or support about?



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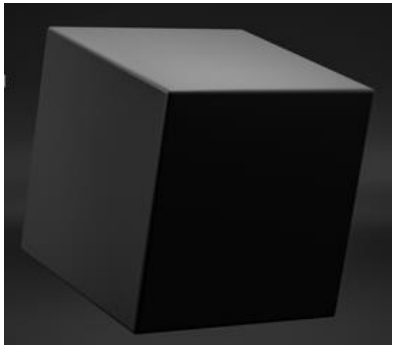

SESSION 2. feedback from groups

- Not a lot of experience in these approaches; not come across them
  - Though some positive experiences of taking a consultative approach to action planning e.g. bringing commissioners together and discussing what would be meaningful changes they could bring in
- Felt would be useful; very interesting and lots of potential
  - Keen to try how it would work
  - Underlines the importance of getting the right kind of findings from the SAR
  - Ideas about how it might be accommodated into the SAR Panel process and be used to challenge reviewers
- Some anxiety about
  - The time required to make it work; and getting the right people involved given other demands and capacity issues currently
  - Ideas about whether it prompts a useful rethink about the balance of resource/time dedicated currently to completing a SAR report vs. determining and following up on action
  - Ideas about whether it could be reserved as an approach to findings that are more challenging to know how to tackle, rather than be used routinely; or alternatively be useable routinely but in proportionate ways
- Further resources that would help:
  - Some worked examples, including comparison with ‘SMART’ actions
  - More training and tools/templates to support development of logic & dark logic models
  - An accessible 7-minute briefing to explain the process; using ‘theory of change’ rather than ‘logic model’
  - Further sessions around evaluation and impact; and organisational change
  - Nominated people with expertise in the SAR Champions or BMs group with expertise and availability to be a critical friend for logic models

Thank you!

- SCIE team

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